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No. 02-1845

IN THE

Supreme Court of the United States

AETNA HEALTH INC.,

Petitioner,

v.

JUAN DAVILA,

Respondent.

On Writ Of Certiorari
To The United States Court Of Appeals
For The Fifth Circuit

REPLY BRIEF FOR PETITIONER AETNA HEALTH INC.

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RULE 29.6 STATEMENT

The corporate disclosure statement included in the petition for a writ of certiorari remains accurate.

TABLE OF CONTENTS

Page

RULE 29.6 STATEMENT i

TABLE OF AUTHORITIES iii

ARGUMENT 2

I. Aetna Provides Plan Administration Services, Not Medical Treatment 2

II. Davila's THCLA Claim Falls Within The Scope Of Section 502(a) 10

III. The Section 514 Principles On Which Davila Relies Are Inapposite 14

IV. The Court Should Decline The Invitation To Overrule The *Pilot Life* Line Of Cases 18

CONCLUSION 20

TABLE OF AUTHORITIES

Page(s)

Cases

Allied-Bruce Terminix, Inc. v. Dobson, 513 U.S. 265 (1995) 19

Allis-Chalmers Corp. v. Lueck, 471 U.S. 202 (1985) 11, 12

Arana v. Ochsner Health Plan, 338 F.3d 433 (5th Cir. 2003) (en banc), *cert. denied*, 124 S. Ct. 1044 (2004) 17

Bell v. Hood, 327 U.S. 678 (1946) 13

Black & Decker Disability Plan v. Nord, 123 S. Ct. 1965 (2003) 7, 8

Boggs v. Boggs, 520 U.S. 833 (1997) 9

Buckman Co. v. Plaintiffs' Legal Committee, 531 U.S. 341 (2001) 17

California Division of Labor Standards Enforcement v. Dillingham Construction, N.A., 519 U.S. 316 (1997) 9

Caterpillar Inc. v. Williams, 482 U.S. 386 (1987) 11, 12, 13, 14

City of Chicago v. International College of Surgeons, 522 U.S. 156 (1997) 18

Decatur Memorial Hospital v. Connecticut General Life Insurance Co., 990 F.2d 925 (7th Cir. 1993) 6

Egelhoff v. Egelhoff, 532 U.S. 141 (2001) 9

Emard v. Hughes Aircraft Co., 153 F.3d 949 (9th Cir. 1998) 7

Ervast v. Flexible Products Co., 346 F.3d 1007 (11th Cir. 2003) 17

Fort Halifax Packing Co. v. Coyne, 482 U.S. 1 (1987) 19

Franchise Tax Board v. Construction Laborers Vacation Trust, 463 U.S. 1 (1983) 13

Hull v. Fallon, 188 F.3d 939 (8th Cir. 1999) 5

IBEW v. Hechler, 481 U.S. 851 (1987) 11, 12

Ingersoll-Rand Co. v. McClendon, 498 U.S. 133 (1990) 9, 17

Joyce v. RJR Nabisco Holdings Corp., 126 F.3d 166 (3d Cir. 1997) 17

Kennedy v. Connecticut General Life Insurance Co., 924 F.2d 698 (7th Cir. 1991) 13

Lockheed Corp. v. Spink, 517 U.S. 882 (1996) 7

Massachusetts Mutual Life Insurance Co. v. Russell, 473 U.S. 134 (1985) 19

Mertens v. Hewitt Assocs., 508 U.S. 248 (1993) 14

Metropolitan Life Insurance Co. v. Taylor, 481 U.S. 58 (1987) 9, 12, 13, 14, 17, 20

Oklahoma City v. Tuttle, 471 U.S. 808 (1985) 16

Pegram v. Herdrich, 530 U.S. 211 (2000) 8

Pilot Life Insurance Co. v. Dedeaux, 481 U.S. 41 (1987) 1, 2, 7, 12, 16, 20

Republic Steel Corp. v. Maddox, 379 U.S. 650 (1965) 12

Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355 (2002) 7, 11, 16

South Central Bell Telephone Co. v. Alabama, 526 U.S. 160 (1999) 16

Steel Co. v. Citizens for a Better Environment, 523 U.S. 83 (1998) 13

Tovey v. Prudential Insurance Co. of America, 42 F. Supp. 2d 919 (W.D. Mo. 1999) 17

UNUM Life Insurance Co. v. Ward, 526 U.S. 358 (1999) 11

Federal Statutes

15 U.S.C. § 1012 15

21 U.S.C. § 353(b) 4

LMRA § 301, 29 U.S.C. § 185 17

ERISA § 3(1), 29 U.S.C. § 1002(1) 18

ERISA § 3(3), 29 U.S.C. § 1002(3) 18

ERISA § 4, 29 U.S.C. § 1003 18

ERISA § 502(a), 29 U.S.C. § 1132(a) ..... *passim*

ERISA § 514, 29 U.S.C. § 1144 ..... 14, 15, 16, 17, 18

ERISA § 514(a), 29 U.S.C. § 1144(a) 16, 18

ERISA § 514(b), 29 U.S.C. § 1144(b) 15

ERISA § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B) 15

42 U.S.C. § 300e-10(a) 4

Pension Annuitants Protection Act of 1994, Pub. L. No. 103-401, 108 Stat. 4172 20

Federal Regulations

29 C.F.R. § 2560.503-1 14

Court Rules

SUP. CT. R. 15.2 15

State Law

TEX. CIV. PRAC. & REM. CODE § 88.001(5) 9

TEX. CIV. PRAC. & REM. CODE § 88.002(c)(2) 10

TEX. CIV. PRAC. & REM. CODE § 88.002(d) 10

1990 Kan. Op. Att'y Gen. No. 90-130, 1990 WL 547153 5

1999 Ohio Op. Att'y Gen. 265, 1999 WL 692623 5

Court Documents

Brief for Respondent, *Pilot Life Insurance Co. v. Dedeaux*, No. 85-1043 (Oct. 31, 1986) 16

Other Authorities

American Medical Ass'n, *Code of Ethics* (2002) 6

ECONOMIC REPORT OF THE PRESIDENT (2004) 19

Health-Care Tab Hits $1.7 Trillion, WALL ST. J., Feb. 12, 2004, at D2 19

J. Scott Andresen, *Is Utilization Review the Practice of Medicine?*, 19 J. LEGAL MED. 431 (1998) 5

REPLY BRIEF FOR PETITIONER AETNA HEALTH INC.

This Court granted review to examine the Fifth Circuit's holding that a challenge to Aetna's "refus[al] to cover"—*i.e.*, pay for—a particular medication is not completely preempted by ERISA because that challenge was artfully framed as a "tort" claim for "damages" rather than an ERISA "contract" claim for "benefits." Aetna Pet. App. 2a, 16a. We restate the Fifth Circuit's holding because respondents evidently have no desire to defend the decision below on its own terms. Instead, respondents and their *amici* advance several theories designed—covertly or overtly—to persuade this Court to modify or abandon *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987), and its progeny. Those theories—some of which are advanced for the first time in this Court—no more support the judgment below than did the Fifth Circuit's discredited, and largely abandoned, reasoning.

Davila and his *amici* now defend the outcome reached by the Fifth Circuit based on four premises, each of which is faulty legally or factually—or both. *First*, they repeatedly assert that Aetna provided "medical treatment" to Davila or that Aetna engaged in "medical malpractice," when in fact and law Aetna's role was limited to making a coverage determination under the ERISA plan. *Second*, they contend that Davila's state-law tort claim is not within the scope of ERISA § 502(a), 29 U.S.C. § 1132(a), even though he could have challenged Aetna's decision under ERISA but chose not to do so. *Third*, they argue that Section 514 of ERISA should limit the complete-preemption analysis under Section 502, an argument that respondents clearly waived and this Court has already rejected. *Fourth*, and finally, they urge this Court to depart from two decades of settled precedent, but principles of statutory *stare decisis* preclude such a result.

ARGUMENT

I. Aetna Provides Plan Administration Services, Not Medical Treatment

Pilot Life held, and this Court has repeatedly reaffirmed, that Section 502(a) of ERISA provides the exclusive avenue for challenging allegedly improper denials of benefits under ERISA plans. *Pilot Life*, 481 U.S. at 52. Davila and his *amici* posit, however, that States traditionally have used their police powers to regulate "health care," and that such authority may be invoked to regulate health insurers' *coverage* decisions because such decisions, as a practical matter, "control" medical treatment or care.[1] Davila's attempt to label his state-law claim one for alleged "medical malpractice," however, cannot paper over the fundamental divide between coverage decisions and treatment.

Whatever power States retain to regulate "health care" in the abstract, Congress clearly intended ERISA to regulate the health *benefits* at issue here. That eligibility for such benefits may turn, in part, on medical criteria does not change the analysis: any welfare plan that provides *health* insurance necessarily uses medical criteria to delimit the scope of coverage.[2] Here, because Davila incontrovertibly challenges the propriety of Aetna's benefit determination—a coverage decision, whether or not it was based on any medical criteria—his state-law claim is completely preempted under *Pilot Life*.

1. As our opening brief demonstrated, Aetna's role under the Monitronics Plan is to make "[d]eterminations regarding eligibility for benefits, coverage for services, benefit denials and all other terms of this Certificate." J.A. 78 (boldface omitted). The Plan also explains that it "applies to coverage only and does not restrict a Member's ability to receive health care services that are not, or might not be, Covered Benefits." *Id.* at 40, 108 (boldface and capitalization omitted). And the Plan makes clear that "[i]f the Member's [physician] performs, suggests, or recommends a Member for a course of treatment that includes services that are not Covered Benefits, the entire cost of any such non-covered services will be the Member's responsibility." *Id.* at 46 (boldface omitted).[3] These provisions refute Davila's repeated claims that Aetna's role is to provide medical *treatment*. Tellingly, the Plan itself is *nowhere* addressed in the hundreds of pages of briefs submitted by Davila and his *amici*.

Even if the Monitronics Plan did not make this point so clearly, Aetna could not make medical "treatment" decisions as a matter of law. Insurers (including Aetna) are not licensed by Texas or any other State to practice medicine. In-

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[1] *E.g.*, Resp. Br. 11 ("These are two medical-malpractice actions"), 28 ("the claim is one for defective medical care"), 65 ("the state law substantively regulates medical decision-making").

[2] "Medical necessity" plan terms also incorporate criteria *other* than medical factors. Aetna Br. 5-6; J.A. 54-55.

[3] The Plan also states, unambiguously, that "Participating Providers [*i.e.*, physicians] are not agents or employees of [Aetna]" and that they "are *solely* responsible for any health services rendered to their Member patients." J.A. 31 (emphasis added; boldface omitted). Davila contends, based on contracts *not* in the record, that Aetna requires its participating physicians to "comply" with its "medical-necessity decisions" (Resp. Br. 3 n.3), and thus legally prevents doctors from making independent treatment decisions. But the cited contracts establish only that physicians must "comply" with Aetna's "participation criteria" and "policies"—matters such as precertification requirements, confidentiality of medical records, or electronic submission of referrals. *E.g.*, Resp. Br. App. 19a. And other provisions of the same contracts—omitted from Davila's appendix—make clear that providers may freely offer members services not covered by Aetna, so long as the lack of coverage is clear to the patient. App., *infra*, 3a-4a.

deed, under the federal HMO Act, States cannot impede the formation of HMOs by requiring that licensed physicians have any particular role in the formation or management of an HMO. *See* 42 U.S.C. § 300e-10(a). Nor can Aetna or any other insurer prescribe any medications: prescriptions can be written only by a licensed physician. 21 U.S.C. § 353(b). Here, contrary to the overheated rhetoric of Davila's *amici* (*e.g.*, CCHCC Br. 6; AMA Br. 11), Aetna did not prescribe Naprosyn for Davila's condition. It was entirely up to Davila's physician—Dr. Lopez—whether to prescribe Vioxx (out of plan, if necessary), Naprosyn, or any other non-steroidal anti-inflammatory drug (NSAID) covered under the Monitronics Plan.[4] The decision to prescribe Naprosyn in particular was undoubtedly a "treatment" decision, but it clearly was one that was made by Dr. Lopez, not Aetna.[5]

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[4] Under the formulary, Davila could have obtained Vioxx coverage by showing intolerance, allergy, or contraindication to, or unsatisfactory results with, *any two* generic NSAIDs, some of which are considerably more expensive than naproxen (the generic name for the brand name Naprosyn) but nonetheless are covered without precertification. *See* Aetna Br. App. 29a.

[5] Citing the allegations of his complaint, Davila now suggests that Aetna somehow prevented him from obtaining Vioxx on his own, since "he could not even get his pharmacy to fill [Dr. Lopez's] prescription [for Vioxx]." Resp. Br. 6. But even the complaint does not assert that Aetna prevented Davila from obtaining Vioxx out of plan; the complaint alleges instead that "[w]hen [Davila] tried to fill the [Vioxx] prescription, . . . he was informed that his insurer . . . would not fill it." Aetna Pet. App. 67a. In other words, Aetna declined to *pay for* Vioxx. Davila remained free to have the Vioxx prescription filled at his own expense, following which he (or his physician, as his representative or assignee) could have pressed his claim to coverage by filing an internal appeal, seeking IRO review, or bringing an action for reimbursement under ERISA. Nothing in the record—or in common sense or experience—suggests that the *pharmacist* would not "fill" (*i.e.*, dispense) a valid prescription provided that Davila agreed to pay for it by means other than his ERISA-governed health plan.

The *amici* States now assert that "HMOs' medical necessity determinations dictate treatment through the 'utilization review' process." States' Br. 8. Not surprisingly, however, several of the same States have long recognized in formal opinions that this is simply not true. *See, e.g.*, 1999 Ohio Op. Att'y Gen. 265, 1999 WL 692623, at *4 (an "adverse determination" by an HMO "does not mean that the physician is precluded from providing the service or that the patient is precluded from obtaining the service from another source or through other means"); 1990 Kan. Op. Att'y Gen. No. 90-130, 1990 WL 547153, at *3 ("Care is not being administered or withheld by the reviewing person. . . . An insured who is denied benefits by utilization review, on the grounds that the treatment sought is not 'medically necessary' . . . , is not prevented from obtaining medical care"); *accord Hull v. Fallon*, 188 F.3d 939, 943 (8th Cir. 1999). *See generally* J. Scott Andresen, *Is Utilization Review the Practice of Medicine?*, 19 J. LEGAL MED. 431, 441-45 (1998).[6]

Similarly, although the American Medical Association makes the remarkable—and demonstrably false—assertion

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[6] Insurance coverage creates an incentive for an insured to avail himself of covered services even when they are unnecessary; utilization review allows plans to mitigate this incentive while still covering a wide variety of treatments. *See* Aetna Br. 5. Vioxx has been found to be particularly susceptible to this moral-hazard incentive. *See, e.g.*, Jalpa A. Doshi et al., *The Impact of Drug Coverage on COX-2 Inhibitor Use in Medicare*, HEALTH AFFAIRS Web Exclusive, Feb. 18, 2004, http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.94v1.pdf, at W4-102 ("[I]rrespective of the [gastrointestinal] risk, people with the most generous prescription plans in 2000 were more likely to use COX-2 inhibitors [such as Vioxx]").

that Davila did not "receive[] the course of treatment prescribed by his . . . treating physician" (AMA Br. 20), the AMA's own Code of Ethics specifically addresses the situation presented in this case, and it makes clear that the choice of medication is ultimately the patient's (in consultation with his physician), not the insurer's:

> If physicians *exhaust all avenues to secure a formulary exception* for a significantly advantageous drug, they are still obligated to disclose the option of the more beneficial drug to the patient, *so that the patient can consider whether to obtain the medication out-of-plan*. Under circumstances in which the health care program will not subsidize the drug, *physicians should help patients by identifying alternative forms of financial assistance*, such as those available through pharmaceutical companies' assistance programs.

Am. Med. Ass'n, *Code of Ethics* § E-8.135(6) (2002) (emphases added). And, according to the AMA's own Code of Ethics, doctors may recommend a covered medication only if it is just as efficacious as any non-covered medication. *See id.* § E-8.135(2); *see also* AMA Br. 9 (patients are protected by physician self-regulation). If physicians disagree with denials of coverage, they may provide the recommended care or services and pursue the ERISA beneficiaries' rights to payment themselves, pursuant to the assignment of benefits taken at the outset of providing care. *See, e.g., Decatur Mem'l Hosp. v. Conn. Gen. Life Ins. Co.*, 990 F.2d 925, 926-27 (7th Cir. 1993).

2. The formulary exclusion of coverage for Vioxx under circumstances like Davila's does not constitute "medical treatment." Davila elected to enroll in an employer-sponsored managed care plan whose prescription coverage was subject to formulary requirements. Plainly, this Court's cases would not allow Davila to sue Aetna in state court for harm resulting from a denial of Vioxx (however strongly his

doctor recommended it) if the Plan provided that Vioxx is *never* a covered benefit. The *conditional* inclusion of Vioxx in the Plan's formulary does not alter either the relevant legal analysis or the conclusion.

Nothing in ERISA requires employers to establish employee benefits plans, or to provide any particular benefits if they do choose to have such a plan. Rather, employers have great leeway to design welfare plans as they see fit. *See Black & Decker Disability Plan v. Nord*, 123 S. Ct. 1965, 1970, 1971 (2003); *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996). And once an employer chooses to provide a particular benefit under a welfare plan, *all* claims of improper denial of that benefit must be brought under ERISA. *Pilot Life*, 481 U.S. at 52. As this Court has emphasized repeatedly, ERISA's policy is to "induc[e] employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred." *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 379 (2002). The AMA's suggestion that Aetna should be held liable for the formulary's limitations on *coverage* for Vioxx would allow state tort law retroactively to undo Davila's and his employer's coverage decision and to rewrite his insurance into a more expansive, and expensive, plan that neither of them selected or paid for.

By conflating the structuring of benefits with the provision of treatment, Davila and his *amici* are asking this Court to take an even larger step than the one rejected last Term in *Nord*. There, as here, eligibility for benefits under an ERISA welfare plan turned on assessing medical criteria. The unanimous opinion in *Nord* rejected the notion that ERISA plan administrators must give "more weight" to the opinion of a treating physician: benefits administration, the Court held, involves interpretation of the plan, which is not subject to reasonableness review under *medical* standards. 123 S. Ct.

at 1972 & n.4. The argument advanced by Davila and the AMA here would effectively require the administrator to give *conclusive* weight to the opinion of a treating physician and to pay for anything he recommends—or face the prospect of potentially unlimited tort damages in state court for breaching a purported state "duty of care." If ERISA does not permit a rule that grants special weight to a treating physician's judgment even in a federal suit for the benefits in question, it is difficult to see how Davila's bid for a supplemental state-court remedy to enforce that same professional judgment can be squared with ERISA.

3. To sow confusion where there is none, Davila and his *amici* recite this Court's reference in *Pegram* to a "puzzling issue of preemption" that justified reluctance to infer an ERISA case of action in that case. Resp. Br. 28 (quoting *Pegram v. Herdrich*, 530 U.S. 211, 236 (2000)) (internal quotation marks omitted). But however "puzzling" the issue might be in the context of the "mixed" decisions made by a physician owner of a group-model HMO (or a staff-model HMO, where treating physicians, like the defendant in *Pegram*, also make both coverage and treatment decisions), the issue is entirely straightforward where, as here, coverage and treatment are clearly separated. Davila offers no response to this distinction other than the question-begging assertion that HMOs "should not be permitted to avoid malpractice liability" by adopting this structure. Resp. Br. 36. But by engaging only in benefits administration—which ERISA regulates exclusively, leaving no room for additional state-law medical standards—Aetna has never entered the sphere of traditional *medical* practice that might justify subjecting it to state-law malpractice liability.[7] That sphere is left to physicians.

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[7] As both Davila and the Texas Attorney General state, the THCLA on its face applies even when the HMO provides no medical treatment, if the plaintiff shows that the HMO's coverage decision had some effect on the care ultimately provided by the physician. *See* TEX. CIV. PRAC. & REM. CODE § 88.001(5).

4. Davila's erroneous assertion that he is challenging health care "treatment" decisions—purportedly an area of "traditional" state regulation—forms the principal basis for his attempt to save his THCLA claims from preemption. *See, e.g.*, Resp. Br. 17. But Davila himself refutes his own contention by conceding that the THCLA is not "traditional" regulation of medicine at all, since it was enacted to supplement *and expand* "traditional malpractice law." Resp. Br. 4 ("Texas concluded that traditional malpractice law . . . accorded little real protection").

Moreover, even if the THCLA could be viewed as part of the States' "traditional" regulation of medicine, Davila still could not avoid *Pilot Life* and its progeny. States "traditionally" engaged in numerous forms of regulation that now are clearly barred by ERISA, including—until *Pilot Life*—punishing certain coverage decisions directly through the tort of "bad faith" or through punitive damage awards. ERISA's language, and this Court's decisions in *Pilot Life* and *Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58 (1987), make clear that those state efforts are now completely pre-empted. As this Court has noted, "ERISA certainly contemplated the pre-emption of substantial areas of traditional state regulation." *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A.*, 519 U.S. 316, 330 (1997); *see also Egelhoff v. Egelhoff*, 532 U.S. 141, 151 (2001) (domestic relations); *Boggs v. Boggs*, 520 U.S. 833, 849-50, 852 (1997) (same). In particular, it has long been clear to this Court that, notwithstanding any general presumptions against preemption, "the exclusive remedy provided by § 502(a) is precisely the kind of special feature that warrants pre-emption." *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 144 (1990) (internal quotation marks and alterations omitted).

II. Davila's THCLA Claim Falls Within The Scope Of Section 502(a)

Stripped of the litigation-driven fiction that Aetna provides medical treatment to HMO participants, Davila's claim amounts to nothing more than the contention that Aetna erroneously declined to pay for Vioxx. That is nothing other than an ERISA claim. Indeed, Davila concedes that he could have invoked ERISA remedies when Aetna refused to pay. Resp. Br. 13. That concession should be dispositive of this case.

1. Davila's THCLA claim attacks Aetna's interpretation of the plan to deny coverage, demanding punitive and compensatory damages for Aetna's alleged failure to comply with a state-law standard of "ordinary care." Contrary to Davila's contention (*e.g.*, Resp. Br. 26) that the THCLA creates a duty wholly independent of those created by the ERISA plan and does not require plan interpretation, the THCLA cause of action expressly *incorporates* the scope of coverage mandated by the plan document. TEX. CIV. PRAC. & REM. CODE § 88.002(d).[8] If an HMO denies benefits that are "not covered by the health care plan," it is not liable under the THCLA; conversely, if it denies benefits that *are* covered under the plan, it may be liable under the THCLA. *Id.*[9]

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[8] Indeed, the Attorney General of Texas admits as much, *see* States' Br. 14-15 ("[T]he plain text of the THCLA . . . establish[es] that the provision will not be read to impose an obligation that is not covered by the agreed health plan"), thus negating his own assertion that the THCLA "imposes liability for failure to follow professional standards of ordinary care, not for failure to fulfill the benefit-plan agreement," *id.* at 14.

[9] If the HMO promptly approves benefits, covered or not, it cannot be held liable under the THCLA. TEX. CIV. PRAC. & REM. CODE § 88.002(c)(2).

Thus, far from adding a substantive plan term that could permissibly be enforced *under ERISA*, *see, e.g.*, *Rush Prudential*, 536 U.S. at 379-80; *id.* at 399 (Thomas, J., dissenting); *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358, 376-77 (1999), the THCLA attempts to impose additional liability on a subset of HMOs for failing to fulfill the very same duty that ERISA imposes—to pay benefits in accordance with plan terms. Davila and his *amici* therefore are entirely incorrect to assert (*e.g.*, Resp. Br. 20; Cmty. Rights Counsel Br. 19) that the THCLA claim does not involve determining whether coverage was correctly denied under the plan. Such a determination is an essential predicate to liability under the Texas law. *See also* U.S. Br. 14. For that reason, it is impossible to avoid the conclusion that the THCLA is precisely the type of supplemental enforcement mechanism that is precluded by Section 502(a)'s exclusive remedial scheme.

2. The LMRA cases that Davila cites as authoritative (Resp. Br. 25, 27) in fact make clear that the THCLA claim is completely preempted by Section 502(a). The THCLA claim turns on interpretation of the plan document, because it makes the denial of benefits *covered by the plan* grounds for award of a supplemental state-law remedy. In the analogous LMRA context, this Court has clearly held that if a state-law claim requires interpretation of the collective bargaining agreement, it is completely preempted. *See IBEW v. Hechler*, 481 U.S. 851, 862 (1987); *Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202, 214-15, 219-220 (1985).[10]

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[10] Davila does not cite or discuss *Allis-Chalmers* or *Hechler*, which are acknowledged as controlling in the LMRA-preemption cases he *does* cite. *E.g.*, *Caterpillar Inc. v. Williams*, 482 U.S. 386, 394-95 (1987). The consistent rule of this line of cases is this: State-law claims are completely preempted if they involve interpretation of the federally covered contract, *i.e.*, the collective bargaining agreement or ERISA plan. *Lingle v. Norge Div. of Magic Chef, Inc.*, 486 U.S. 399, 407-08 & n.7 (1988); *Caterpillar*,

3. Davila asserts that his complaint cannot be recharacterized as alleging a Section 502(a) claim because he forwent the Vioxx and, thus, cannot now seek reimbursement for it. *E.g.*, Resp. Br. 22, 28. The twin holdings of *Pilot Life* and *Metropolitan Life*—that Congress crafted Section 502(a) to be exclusive and to federalize any state-law claim that disrupts that exclusivity—would be utterly undone by accepting Davila's view that he can obtain state-law remedies merely by waiting until ERISA remedies can no longer help him. *Cf. Republic Steel Corp. v. Maddox*, 379 U.S. 650, 653 (1965) ("A . . . rule which would permit an individual employee to completely sidestep available grievance procedures in favor of a lawsuit has little to commend it").

Davila plainly had a remedy under Section 502(a)—a suit to enforce his rights under the Monitronics Plan after exhausting his internal appeal rights. He attempts to avoid ERISA preemption by arguing that because he cannot *now* sue (as he no longer seeks the Vioxx and incurred no expense that can be reimbursed), his state-law claim is viable and cannot be removed. Resp. Br. 22. Davila's argument—that Congress carefully delimited the remedies available under ERISA, only to allow plaintiffs to overcome those limitations at will by waiving their federal remedies—is contrary to both common sense and settled principles of federal jurisdiction. A claim ostensibly pleaded under state law but falling within

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482 U.S. at 395; *Hechler*, 481 U.S. at 862; *Allis-Chalmers*, 471 U.S. at 218. Davila has *no* relationship with Aetna outside the confines of his ERISA plan (whereas he *does* have such a relationship with his treating physician), and his THCLA claim expressly turns on interpretation of that plan, *see supra* pp. 10-11. *Compare Caterpillar*, 482 U.S. at 396-97 (claim depended entirely on a contract *other than* the collective bargaining agreement). Under the LMRA cases, therefore, Davila's claim plainly is completely preempted—whether pleaded in tort or contract. *See Allis-Chalmers*, 471 U.S. at 213-15.

the exclusive scope of Section 502(a) is one arising under federal law. *Metropolitan Life*, 481 U.S. at 66, 67. Such a claim, like any other within federal question jurisdiction, may be brought in or removed to federal court even if it does *not* state a *viable* claim on the merits. *See Steel Co. v. Citizens for a Better Env't*, 523 U.S. 83, 95-96 (1998); *Bell v. Hood*, 327 U.S. 678, 682 (1945); *see also Kennedy v. Conn. Gen. Life Ins. Co.*, 924 F.2d 698, 700-01 (7th Cir. 1991) (Easterbrook, J.). For this reason, this Court has expressly *rejected*, as "squarely contrary" to precedent, the argument that complete preemption is unavailable "unless the federal cause of action relied upon provides the plaintiff with a remedy." *Caterpillar Inc. v. Williams*, 482 U.S. 386, 391 n.4 (1987). *Metropolitan Life*—the sole cited source for Davila's proposed rule—holds that within Section 502(a)'s scope, only federal claims are possible (*see* 481 U.S. at 64, 66); it does *not* hold that only if federal relief is possible does a claim fall within Section 502(a)'s scope.

This Court sent no contrary signal in *Franchise Tax Board v. Construction Laborers Vacation Trust*, 463 U.S. 1 (1983), on which Davila and his *amici* rely for the proposition that complete preemption should be construed narrowly. Resp. Br. 20-24. *Franchise Tax Board*, which antedated both *Metropolitan Life* and *Caterpillar*, is inapposite because it specifically left open the question presented here—*i.e.*, whether plan beneficiaries' state-law claims are federalized if they fall within the scope of Section 502(a)—and that question was later expressly *answered* in *Metropolitan Life*. *See* 481 U.S. at 64. The Franchise Tax Board's collection action did not fall within the scope of Section 502(a) because *at no time* did that provision give it a remedy: state agencies—unlike plan beneficiaries—are not proper plaintiffs under Section 502(a). 463 U.S. at 25-27. Taylor, by contrast, was a plan beneficiary who could have challenged plan-administration decisions under ERISA but sought state-law damages instead, placing his complaint—like Davila's—

within the scope of Section 502(a). *See* 481 U.S. at 61. That suffices to confer removal jurisdiction: it has been clear since the first complete-preemption case that there is no additional requirement that the plaintiff state a *viable* federal claim. *See Caterpillar*, 482 U.S. at 391 n.4.

4. The assertion that there can be no preemption in this area because Congress has failed to create a remedial scheme, or that displacing state law would leave behind a "regulatory vacuum" (Resp. Br. 41), is simply inaccurate. Congress *has*, in fact, created a thoroughly detailed remedial scheme, which the Secretary of Labor has amplified by imposing specific and detailed requirements on the internal appeals process that, in most cases, should obviate the need for litigation at all. 29 C.F.R. § 2560.503-1. When plaintiffs properly resort to litigation, remedies are available—not *every* remedy a plaintiff might desire, but as this Court has held, ERISA "resolved innumerable disputes between powerful competing interests—not all in favor of potential plaintiffs." *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 262 (1993). ERISA favors prospective remediation in the hope that judicial review will prove unnecessary; where retrospective litigation is necessary, however, *all* members of this Court have *repeatedly* agreed that Congress refused to permit recovery of the punitive damages Davila seeks. *See* Aetna Br. 20-21.

III. The Section 514 Principles On Which Davila Relies Are Inapposite

Davila and his *amici* mount a further assault on *Pilot Life* and its progeny by attempting, first, to import into the Section 502(a) preemption analysis the distinct requirements of "relates to" preemption under ERISA § 514, 29 U.S.C. § 1144, and then to invoke exceptions to the latter species of preemption. Most of those arguments are waived because Davila never raised them before his brief on the merits in this Court. All are, in any event, meritless.

1. Davila contends that the "insurance savings clause" and the federal-law exception found in ERISA's general defensive-preemption provision, Section 514, must also be read to qualify the preemptive effect of any other provision of ERISA, and in particular that those provisions should limit Section 502(a)'s preemptive force. With respect to the federal-law exception, Davila attempts to invoke the McCarran-Ferguson Act, 15 U.S.C. § 1012, which has no substantive effect other than to create a *presumption* that federal statutes do not displace state insurance regulation—a presumption rebutted by ERISA, which delineates in Section 514(b) which state insurance laws are saved and which are not.[11]

a. At no point in this litigation—in the district court, in the court of appeals, or at the certiorari stage—has Davila previously asserted that Section 514's insurance saving clause or its federal-law exception applies to save his THCLA claims for complete preemption. Davila's merits brief marks the first appearance of this contention.[12] Indeed, in resisting certiorari, Davila actually underscored the distinction between Section 502 and Section 514, noting that "section 502(a) complete preemption is very different from section 514's 'relates to' preemption." Br. in Opp. 1 n.1. Because Davila never suggested to this Court until now that the Fifth Circuit's judgment could be sustained based on Section 514's insurance saving clause or federal-law exception, those contentions are waived. *See* SUP. CT. R. 15.2; *Okla.*

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[11] Indeed, Davila's attempt to import the McCarran-Ferguson Act into ERISA would read Section 514(b)(2)(B)'s "deemer clause" entirely out of the statute.

[12] Respondents halfheartedly claim to have raised the savings clause in the court of appeals (Resp. Br. 51 n.25), but the sources they cite do not bear out that assertion: a Rule 28(j) letter whose discussion of *Rush Prudential* dealt exclusively with Section 502(a), and a footnote referring to the grant of certiorari.

City v. Tuttle, 471 U.S. 808, 815-16 (1985); *see also, e.g., S. Cent. Bell Tel. Co. v. Alabama*, 526 U.S. 160, 171 (1999).

b. It is a bit hard to see how Davila can argue that the THCLA is directed at the "business of insurance," given his primary contention that the Act addresses "medical malpractice." But in any event, this Court has already considered and rejected the notion that Section 514's insurance savings clause negates the complete preemption doctrine in the insurance context. *Precisely* this argument was made to this Court in *Pilot Life*. *See* Br. for Respondent, *Pilot Life Ins. Co. v. Dedeaux*, No. 85-1043, at 6-7, 15-17 (Oct. 31, 1986). This Court rejected that argument, stating that the state tort action was not saved in part *because* it conflicted with Section 502(a). *Pilot Life*, 481 U.S. at 52, 57. Indeed, the Court explained that Section 502(a)'s exclusive remedial scheme was the "most important[]" factor indicating that the state law was not the business of "insurance" that Congress intended to preserve for State regulation. *Id.* at 57; *see also Rush Prudential*, 536 U.S. at 377 (noting that *Pilot Life* "anticipated" that the savings clause "los[es] out" to "the congressional policies of exclusively federal remedies").

In sum, *Pilot Life* teaches that the exclusivity of Section 502's remedies is so essential to the statutory scheme that it must inform whether specific conduct is the business of "insurance" that States may regulate. Put another way, laws that attempt to supplement the exclusive remedies that Congress provided in Section 502 do not address the business of "insurance"; they address the business of ERISA. In resurrecting this waived savings-clause argument seventeen years after its initial rejection, Davila signals yet again the weakness of his arguments for affirming the Fifth Circuit's judgment.

2. Davila also asserts that the "relate to" provision of Section 514(a), the defensive-preemption provision, is a component of the Section 502(a) analysis. This Court has never even hinted that the complete preemption doctrine incorporates *defensive* preemption principles as an additional component of the analysis,[13] and the courts of appeals have largely rejected such an approach as contrary to both the history of Section 502(a) and settled precedent.[14]

First, the complete preemption doctrine under ERISA rests on Congress's express incorporation of the analogous doctrine under the LMRA. That statute has no preemption clause, but as this Court unanimously concluded in *Metropolitan Life*, Congress unambiguously directed that the rights of action under ERISA § 502(a) be given the same exclusive sweep as the right of action under LMRA § 301. *See also, e.g., Tovey v. Prudential Ins. Co. of Am.*, 42 F. Supp. 2d 919, 923 (W.D. Mo. 1999) (citing cases). Davila's contention that the existence of a defensive preemption clause narrows the reach of complete preemption therefore is unavailing, as complete preemption is premised on supplemental state remedies' conflict with the exclusivity of Section 502(a). *See, e.g., Buckman Co. v. Plaintiffs' Legal Comm.*, 531 U.S. 341, 352 (2001); Aetna Br. 39 & n.21.

Second, as Davila himself emphasizes (Resp. Br. 20-22, 24), Section 514 defensive preemption creates a *defense* that

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[13] To the contrary: *Ingersoll-Rand* noted that the Texas cause of action would be completely preempted by Section 502(a) "[e]ven if there were no express pre-emption in this case." 498 U.S. at 142.

[14] The en banc Fifth Circuit recently concluded unanimously that this Court's cases compel the conclusion that defensive preemption is not a prerequisite to complete preemption. *Arana v. Ochsner Health Plan*, 338 F.3d 433, 439-40 (5th Cir. 2003) (en banc), *cert. denied*, 124 S. Ct. 1044 (2004); *accord Ervast v. Flexible Prods. Co.*, 346 F.3d 1007, 1014 (11th Cir. 2003); *see also, e.g., Joyce v. RJR Nabisco Holdings Corp.*, 126 F.3d 166, 171-72 (3d Cir. 1997). *But see Emard v. Hughes Aircraft Co.*, 153 F.3d 949, 953 (9th Cir. 1998).

does not give rise to federal jurisdiction. Section 502(a) complete preemption, by contrast, is *not* just a defense, but a federalizing force that creates a federal cause of action *despite* the plaintiff's attempt to avoid pleading one. Thus, a federal court to which a completely preempted claim is removed must first satisfy itself of removal jurisdiction by deciding whether the claim falls within the scope of Section 502(a). *See, e.g.*, *City of Chicago v. Int'l Coll. of Surgeons*, 522 U.S. 156, 163, 165 (1997) ("The propriety of removal . . . depends on whether the case originally *could* have been filed in federal court" (emphasis added)). If it does, the plaintiff's claim is recharacterized as necessarily federal and any contrary aspects of the putative state-law claim are displaced, with no further need to assert the defense created by Section 514(a), whose sole effect is to displace state laws. For those reasons, it is implausible to assert that the Section 514's "relate to" analysis is somehow *antecedent* to the Section 502(a) question, when standard removal procedure dictates precisely the opposite.

IV. The Court Should Decline The Invitation To Overrule The *Pilot Life* Line Of Cases

This Court has already given plenary consideration to the issues raised in this case on multiple occasions. As we show above, the particular benefits at issue here and in *Pilot Life* and *Metropolitan Life* are not materially distinguishable; ERISA subjects welfare benefit plans to the same uniform federal regulatory and remedial regime. *See* ERISA §§ 3(1), 3(3), 4, 29 U.S.C. §§ 1002(1), 1002(3), 1003.

Relying on these holdings, employers have structured welfare benefit plans, and managed care companies and other service providers have priced their services, all in the expectation that they will be subject to ERISA's remedial scheme, with its focus on internal dispute resolution and prospective relief rather than courtroom litigation and exemplary damages. *See, e.g.*, Aetna Br. 2-3, 43; AAHP-HIAA Br. 25-26;

Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 10-11 (1987) (unpredictable litigation burdens may well cause "employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them").[15] The reliance interest thus created in one of the largest sectors of the economy is reason in and of itself to continue to adhere to *Pilot Life* so long as the statutory text interpreted in that case remains unchanged. *See, e.g.*, *Allied-Bruce Terminix, Inc. v. Dobson*, 513 U.S. 265, 272 (1995); *id.* at 283-84 (O'Connor, J., concurring). In stark contrast to these tangible interests, the "settled expectations" marshaled by Davila on the other side of the scale (Resp. Br. 66-67)—*i.e.*, the public's interest in "federalism," which is to say in States' supposed ability to override long-settled federal law in the name of "protect[ing] . . . safety"—smack more of sloganeering.

Davila insists that this Court retains unfettered discretion to abandon *Pilot Life* and the cases that have built on it, on the theory that what this Court has "judicially implied" it may freely recant. But that notion utterly discounts the basis of *Pilot Life* and *Metropolitan Life*. In both cases (as in *Massachusetts Mutual Life Insurance Co. v. Russell*, 473 U.S. 134 (1985), before them), this Court held that *Congress* had clearly made the choices that the Court must implement: to subject welfare benefits to the ERISA remedial scheme; to

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[15] A departure from that regime would undoubtedly increase the already high cost of employer-provided health insurance. *See generally* ECONOMIC REPORT OF THE PRESIDENT ch. 11 (2004). Though Davila and his *amici* quibble over percentages, it is uncontested that even a *fractional* increase in health care costs would add tens of billions of dollars to the nation's health care bill. *See, e.g.*, *Health-Care Tab Hits $1.7 Trillion*, WALL ST. J., Feb. 12, 2004, at D2. The precise dollar figure is, of course, in dispute, *compare* U.S. Chamber Br. 25-26 *with* Resp. Br. at 67—but that dispute serves only to reinforce the propriety of leaving this sort of classically legislative judgment to the political process.

make that remedial scheme thorough but to exclude certain remedies from its scope; and to preempt any state-law right of action that disrupts that exclusivity. *Metropolitan Life*, 481 U.S. at 64-65 (citing *Pilot Life*, 481 U.S. at 54).

If Congress disagrees with this Court's construction of ERISA, or is persuaded that additional remedies should be available to plan participants and beneficiaries, it remains free to legislate in this area. Indeed, Congress *has* added additional remedies to ERISA. *E.g.*, Pension Annuitants Protection Act of 1994, Pub. L. No. 103-401, 108 Stat. 4172. Congress also has considered—but failed to enact—other changes in benefits law, including expanding available remedies, a number of times in recent years. *E.g.*, Aetna Br. 42 n.23. Undaunted, the legislative proponents of those unsuccessful measures now ask this Court to embrace remedies that the Congress as a whole has declined to enact. *See* Br. for Sen. Kennedy et al. 25 (asserting that it is "easier" for this Court to change *Pilot Life* judicially than for Congress to do it legislatively). But those pleas provide no legal basis for eschewing this Court's traditional adherence to statutory *stare decisis*. Because there is no substantial basis for this Court to revisit *Pilot Life*, Davila's state-law claims must fail.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

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February 26, 2004

APPENDIX

THIS AGREEMENT CONTAINS
AN ARBITRATION PROVISION

PRIMARY CARE PHYSICIAN AGREEMENT

Dear Primary Care Physician:

* * * *

3.0 COMPENSATION

3.1 Payment. Company's compensation methodologies are designed to promote Member access to quality care. Company shall, or when it is not the applicable Payor shall notify each Payor to, pay Physician for Primary Care Services rendered to Members in accordance with: (a) the Physician Compensation Model as described in the Compensation Schedule; (b) any other applicable Attachment; or (c) the fee schedule then in effect as applicable to such Members' Plans; any of which may be modified from time to time. Physician's compensation for non-capitated Covered Services rendered to Members shall be (A) the lower of (i) the compensation arrangement in effect hereunder, or (ii) Physician's reasonable and customary billed charge, (B) minus any applicable Copayments, Coinsurance or Deductibles. Payments for non-capitated Covered Services are subject to any and all valid and applicable laws related to claims payment. Except for capitated services, in the event Company fails to pay a Clean Claim within forty-five (45) days of submission, upon written notice from Physician of such event, Company shall pay a contracted penalty of **[VARIABLE: one to twenty]** percent **[VARIABLE: (1-20%)]** per month simple interest on the eligible, unpaid portion of such Clean Claim(s), beginning on the 46th day after submission of that Clean Claim through the date on which payment is made. Physician shall not be entitled to billed charges for any Clean Claim. Physician shall not be entitled to receive either billed charges or the contracted penalty for claims under self-funded Plans. Physician shall notify Com-

pany of any overpayments or payments made in error within ten (10) business days of becoming aware thereof, and shall return or arrange the return of any such overpayments or payments made in error to Company, or to Payor or Member, as applicable. Physician shall hold Company, Affiliates, Sponsors, Members and Payors harmless against any and all claims by covering providers related to or arising out of payment for Covered Services rendered to Members. Notwithstanding anything to the contrary in this Agreement, to the extent Company has communicated approval of payment for Covered Services, Company shall pay for such Covered Services absent: (a) fraud; (b) materially changed condition of the Member's health status (meaning a material change in the Member health status between the time that Company communicates approval of payment for Covered Services and the time that those Covered Services are provided, such that the Covered Services for which Company has communicated approval of payment are not medically necessary due solely to the material change in the Member's health); or (c) the individual receiving the services was not a Member at the time such care is delivered. Notwithstanding anything in this Agreement to the contrary, during such time as Physician is a member of a Group, Physician seeks to seek compensation solely from Group for those Covered Services provided to Members and for which Group is compensated by Company on behalf of Physician, and Physician shall in no event bill Company, its Affiliates, Payors or Members for any such Covered Services (except for the collection of Copayments, Coinsurance, Deductibles in accordance with Section 3.2). When Company is not the Payor, Company shall have no obligation to pay Physician in the event that the Payor or Member fails to pay Physician. Company agrees that it shall not offer Physician compensation arrangements that: provide additional compensation for not exceeding certain budgets, impose a penalty for incurring expenses that are medically necessary, make additional compensation available

for limiting medically necessary services or will be affected by the actual (as opposed to projected) costs of services or the actual rate of utilization of services during the contract year. This will not prohibit Company from providing additional compensation to Physician for providing preventive care or in the event the actual costs or utilization of services were more than the projected costs or utilization.

3.2 Billing of Members. Under certain Plans, members may be required to pay Copayments, Coinsurance or Deductibles for certain Covered Services. Physician shall collect any applicable Copayments, Coinsurance and Deductibles from Members. Such amounts collected must be based only on the compensation herein. Copayments shall be collected at the time that Covered Services are rendered. Except for applicable Copayments, Coinsurance and Deductibles, Physician may bill Members only in the circumstances described below:

3.2.1 If the applicable Payor is not an HMO, Physician may bill a Member for Primary Care Services provided to the Member in the event that the Payor becomes insolvent or otherwise breaches the terms and conditions of its agreement to pay, provided that: (a) Physician shall have first exhausted all reasonable efforts to obtain payment from the Payor; and (b) Physician shall not institute or maintain any collection activities against a Member to collect any sums that are owed by a Payor to Physician unless Physician provides prior notice to Company of Physician's intent to institute such activities.

3.2.2 Services that are not Covered Services may be billed to Members by Physician only if: (a) the Member's Plan provides and/or Company confirms that the services are not covered; (b) the Member was advised in writing prior to the services being rendered that the specific services

may not be Covered Services; and (c) the Member agreed in writing to pay such services.

Noting in this section is intended to prohibit or restrict Physician from billing individuals who were not Members at the time that services were rendered.

3.3 Coordination of Benefits. When a Payor is the primary payor under applicable coordination of benefit principles, the Payor shall pay in accordance with this Agreement, and when a Payor is secondary under said principles, Payor's payment shall be limited as specified in the applicable Plan. If the Plan fails to specify coordination of benefits requirements, and unless prohibited by applicable law, Payor's payment shall be limited to the amount which, together with the amount paid by the primary payor following all reasonable efforts by Physician to collect same, equals the compensation due to Physician under this Agreement, or if the primary payor fails to pay, Payor's payment shall be in accordance with this Agreement. In no event shall amounts billed and retained under coordination of benefits for Covered Services exceed Physician's usual and customary billed charges for such services.

3.4 Claims Submission. Physician shall submit claims to Company or the applicable Payor for non-capitated Primary Care Services rendered to Members. Claims shall be submitted within ninety (90) days of the date of service or Physician's receipt of an explanation of benefits from a primary payor. Billings shall include detailed and descriptive medical and Member data and identifying information on HCFA 1500 forms or any subsequent form adopted for that purpose. Physician shall submit bills electronically as required by Company or the applicable Payor. Company primarily utilizes CPT for the coding and description of services. If Physician has not billed Company or the applicable Payor within the stated time frame, Physician's claim shall be deemed waived, and Physician shall not bill any other person or entity, including, but not limited to, Company, the applicable

Payor, Sponsor, or Member, for such services. Company may return to Physician any claims which are incomplete, inaccurate, or not in the proper format as required by Company. Statements made in any claim or related documentation submitted by or on behalf of Physician shall be considered statements made by Physician, regardless of whether such statements are prepared by Physician's employees, agents, or representatives. Any adjustments to claims submitted by Physician must be filed with Company or the applicable payor within thirty (30) days of the submission of the original claim, or the original claim will be deemed final.

3.5 Holding Members Harmless. If the applicable Payor is an HMO, Physician hereby agrees that in no event, including, but not limited to, non-payment by the HMO, insolvency of the HMO or breach of this Agreement, shall Physician bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member or persons (other than the HMO) acting on a Member's behalf for Covered Services. This provision shall not prohibit collection of Deductibles, Coinsurance, or Copayments from Members in accordance with the terms of the Member's Plan.

Physician further agrees that: (a) this provision shall survive termination of this Agreement regardless of the cause giving rise to termination and shall be construed for the benefit of Members; and (b) this provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Physician and a Member or persons acting on a Member's behalf.

Any modifications, additions or deletions to the provisions of this clause shall become effective on a date no earlier than 15 days after the Commissioner of Insurance has received written notice or such proposed changes.

* * * *